

SHIIP Client Information Form

Please provide the following information for our records.

| What is your name on your Medicare of the last of the | | dress on r | | |
|---|---------------------------|---------------------------|---|------------------------------|
| Client Address: | | | | |
| City: | | | | Code: |
| Home Phone | | | | |
| Other Phone | Email Address | | | |
| Representative Information (Son, Da | | |)A) —— | |
| Representative's Name | | | | |
| Rep Address | | | | |
| City | | | | ode |
| Phone | | | | |
| Client Demographics | | | | |
| Date of Birth / / | | | | M F |
| Primary Language English | | | | |
| Annual Income: Individual\$17,505/yr (\$ | 51,458.75/mo) | - | | (\$1,966.25/mo) Below |
| Asset Limits: Individual\$13,440 or Coup | ple\$26,860 | Above _ | | Below |
| On Medicare Due to a Disability (under a | ge 65): | Yes | | No |
| Ethnicity/Race: Please select one of the fol Hispanic, Latino, or Spanish Origin White, Not if Hispanic Origin Black, African-American American Indian or Alaska Native Asian Indian Chinese Filipino Japanese | lowing. | Nati Gua Sam Oth | tnamese ive Hawai nmanian o noan er Asian er Pacific | r Chamorro |
| How did you hear about SHIIP? | | | 3.6.11.1 | 5 |
| Medicare (e.g. 800#, Publication, Main Presentations or Fairs Mailings, Brochures, Posters or News Agency (e.g. AAA, Social Security A Friend or Relative Media (Newspaper, TV, Radio or Other Media (Newspaper, TV, Radio or Other Media (Newspaper) | eletters dministration |) | Pharmac | ee Agency or Provider ontact |

Medicare Prescription Drug Coverage Information Form

Please complete this page if you need a Medicare Part D Comparison

| What is your Medicare (| Claim Number on your I | Aledicare (| card? | |
|--|-----------------------------|-------------|--|------------------------|
| <u> </u> | - | - | | \neg |
| | | | | |
| What is your Medicare | effective date(s)? | | MEDICARE | HEALTH INSURANCE |
| Part AMonth Day Part BMonth Day County | Year - | | SOCIAL SECTION OF BENEFICIARY JOHN D. DOE MEDICARE CLAIM NUMBER 123-45-6789A IS ENTITLED TO HOSPITAL INSURANCE (PA MEDICAL INSURANCE (PA SIGN HERE JOHN D. | (RT B) \(\sqrt{3}/1/99 |
| What is your current dr | ug coverage? | | | |
| None | | or Medica | re Advantage Plan: | |
| Name of | of Plan | | | |
| Employer/Retiree p | olan | VA | Other | |
| How would you like to go (check one): Medicare drug plans Do you currently received Medicaid (Title 19 - Medica | s Medicare Ad | dvantage F | Plans B | oth |
| Help paying your Me | edicare Part B premium (C | QMB, SLM | IB, QI) | |
| Extra Help with your | Medicare drug costs | | | |
| Pay \$1.20 for generic | es and \$3.60 for brand nar | ne drugs | | |
| Pay \$2.55 for generic | es and \$6.35 for brand nar | ne drugs | | |
| Vhat pharmacy do you pi | refer? You may list two. | | | |
| Name of Pharmacy | Address and City | | Phone Number | |
| Name of Pharmacy | Address and City | | Phone Number | |
| SHIIP Use Only: Enroll af | fter Oct 15 Enrolle | d 🗌 | | |
| Premium Payment | Drug List ID: | | | |
| SSA Direct Bill | Password Date: | Month | Date | Year |
| Contact Person: | | | | |

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